OFFICE OF CLAIMS AND APPEALS
CRIME VICTIMS COMPENSATION BOARD

FREQUENTLY ASKED QUESTIONS

- ***What statutes and regulations does the Crime Victims Compensation Board operate under?***
  - The Crime Victims Compensation Board currently operates under Kentucky Revised Statutes Chapter 49 and under Kentucky Administrative Regulations Title 802.

- ***Who are eligible Claimants/victims for purposes of receiving compensation benefits from the Board?***
  - KRS 49.310(1) outlines eligibility requirements for receiving compensation benefits from the Board. They are:
    - A victim of criminally injurious conduct;
    - A surviving spouse, parent, or child of a victim of criminally injurious
    - conduct who died as a direct result of such conduct;
    - Any other person dependent for his principal support upon a victim of
    - criminally injurious conduct who died as a direct result of such crime; and
    - Any person who is legally responsible for the medical expenses or funeral expenses of a victim.

- ***Can my crime related bills be sent to collections before my claim is investigated and decided?***
  - Yes, and in the event that they are, KRS 49.380 provides that: "[u]pon the filing of an application for a claim with the commission, all debt collection actions by a creditor or the creditor's agent, against the claimant for a debt or expense covered under KRS 49.370(3) and related to the substance of the claim shall cease pending a resolution of the claim by the commission, if the claimant: (a) Provides written notice to the creditor or creditor's agent that a claim has been submitted to the commission; and (b) Authorizes the creditor or creditor's agent to confirm with the commission the claimant's application with the commission and that the debt or expense upon which the collection action is based may be covered under KRS 49.370(3)."
  - To this effect, once a claim is accepted for review, a letter entitled Notice of CVCB Investigation will be sent to the Claimant and/or victim. This Notice of CVCB Investigation will need to be completed by the Claimant and/or victim and submitted to each of the creditors that the Claimant and/or victim has a debt to for crime related expenses.
  - This statute's purpose is two-fold: to prevent the re-victimization of the Claimant and/or victim and to mitigate the negative impacts to a Claimant's and/or victim's credit when they cannot afford to pay their crime related expenses.

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  - This statute's purpose is two-fold: to prevent the re-victimization of the Claimant and/or victim and to mitigate the negative impacts to a Claimant's and/or victim's credit when they cannot afford to pay their crime related expenses.

- ***Is filing a claim with the Board an automatic guarantee that my expenses will be paid?***
  - No. Filing a claim with the Board does not mean that payment on the expenses submitted for consideration is automatic. The Board is required to conform to KRS 49 and KAR 802 when determining eligibility for an award.

- ***When do claims need to be filed with the Board?***
  - All claims for crime victims compensation must be filed within five (5) years of the date of the criminally injurious conduct or the date that such conduct is learned. If, however, a claim is not filed within five (5) years, then good cause for the delay in filing must be shown.

- ***What are the requirements for receiving compensation for the Board for my expenses?***
  - If a Claimant and/or victim meets the criteria for eligibility provided for in KRS 49.310, the Claimant and/or victim must do the following:
    - Be an innocent victim of a crime or some type of conduct that could be charged as a crime. ***A conviction is not required***.
    - The incident must be reported to the appropriate law enforcement agency within forty-eight (48) hours of when the incident occurred. If the incident was not reported within forty-right (48) hours, then a justifiable reason must be provided.
    - Claimants generally must cooperate fully with law enforcement and the prosecution. However, exceptions are made for victims of domestic violence and sexual assault.

- ***What types of expenses are compensable by the Board?***
  - The following types of expenses are compensable: medical/dental expenses, funeral/burial expenses, mental health counseling expenses, lost wages, or loss of support.

- ***What types of expenses are <u>not</u> compensable by the Board?***
  - Property damage or loss (with the exception of eyeglasses damaged or destroyed during the commission of the crime)
  - Expenses relating to court proceedings (fuel, parking, lodging, etc.)
  - Household living expenses (rent/mortgage, car note, utility bills, etc.)
  - Relocation expenses
  - Pain and suffering
  - Emotional distress
  - Loss of consortium

- ***What information will I be required to furnish to the Board for my claim?***
  - Specific requirements will vary depending on what type of expenses the Claimant is requesting compensation for from the Board. Generally speaking, however, the requirements are:

- Completed claim form with all sections completed in their entireties, unless a section is marked as optional.
- Police report of the incident.
- Itemized billings from each service provider that the Claimant and/or victim is requesting compensation for. These include itemized medical bills, funeral service contracts, itemized counseling bills, etc.

- More specifically:
  - Medical/dental: see above
  - Funeral/burial: see above with the additional requirement of a copy of a life insurance policy in effect at the time of the victim's death, if applicable.
  - Mental health counseling: see above with the additional requirements of a Mental Health Counselor's Report (provided with the claim form) and a treatment plan from the mental health professional providing services.
  - Lost wages: completed and notarized Employment Verification Form and Physician's Statement (for claims where the lost wages were incurred due to physical injury and both of which are provided with the claim form). If a Claimant and/or victim incurred lost wages due to psychological trauma from the crime, then the Mental Health Counselor's Report, treatment plan, and itemized billings will be required.
  - Loss of support: completed and notarized Employment Verification Form. If the Claimant or victim was self-employed, then the two preceding years' worth of both state and federal tax returns will be required.

- ***What is the general claims process?***
  - Once a claim is filed, the Clerk enters each claim into our database and assigns it a claim number. The Clerk drafts an acknowledgment letter, Notice of CVCB Investigation, and notification letter to the County or Commonwealth Attorney's Office in the event that criminal proceedings have begun against the individual(s) responsible for the crime and sends to the appropriate parties.
  - The Clerk then assigns each claim to one of the investigators for investigation. The investigation of the claim involves, but is not limited to: verification of balances due to service providers/insurance payments/Claimant out of pocket payments; discussion with law enforcement and the prosecution regarding the circumstances surrounding the crime; and obtaining additional information needed from the Claimant and/or service providers. The Clerk may also investigate claims as caseload dictates.
  - Upon the completion of each investigation, the Clerk assigns each claim to one of the Board's three members for a preliminary review and the issuance of a Recommended Order.
  - After the preliminary review, the Board's three members return each claim to the Clerk for placement on a future agenda for a final determination on the awarding or dismissal of a claim.
  - Once a claim is set to appear before the Board, the Clerk drafts and mails the Board Member's Recommended Order to the Claimant and all other required parties. Each Claimant has fifteen (15) days with which to file

exceptions to the Recommended Order in the event that information is incorrect or if the Claimant disagrees with the recommendation for any reason.

- During the monthly Board meeting, the full Board will discuss the claim and any exceptions that may have been filed. Upon such discussion, and after being sufficiently advised, the full Board will render a Final Order. The Clerk then drafts and mails the Final Order to the Claimant and all required parties.
- Upon receipt of the Board's Final Order, the Claimant has the right to appeal the decision by filing a petition for judicial review in either the county where the claim accrued or in Franklin Circuit Court within thirty (30) days from the date that the Final Order is mailed.
- If a claim is awarded by the Board, payment information is drafted by the Clerk and is forwarded to the Finance Cabinet for processing. Treasury checks are issued and sent to the Clerk. The Clerk then enters payments into the database and mails the checks upon receipt.

- ***Does the Board have any caps on payments of claims?***
  - Yes. The Board is limited to rendering a maximum award of $25,000.00 for all expenses that are submitted for a particular claim. Within that $25,000.00 is a cap of $5,000.00 for funeral and/or burial expenses. Funeral and/or burial expenses include funeral costs, monument, and a grave plot.
  - The Board is also limited to paying a maximum of $150.00 per week for lost earnings or loss of support compensation.

- ***How can I obtain a claim form?***
  - You can either go to the Board's website (http://kycc.ky.gov) and access the claim form there or you can call the Board's office at 502-782-8255 and one of the Board's staff will be happy to assist you. Please note that the Board does not possess the ability to accept claim forms completed online at this time.

- ***How should I file my claim?***
  - There are several ways that a Claimant and/or victim can file their claim: walk-in, USPS or other mail delivery service, facsimile, or email at crimevictims@ky.gov. The Board's fax number and email address is provided on the first page of the claim form.

- ***Whom should I contact with any questions about the Board's Crime Victims Compensation Program?***
  - Programmatic questions regarding the Board's Crime Victims Compensation Program can be forwarded to Clerk Raymond Shields at (502) 782-8255 or to raymond.shields@ky.gov. Legal questions can be submitted to the Staff Attorney.

- ***Can a Claimant submit additional bills to the Commission after filing the claim?***
  - Yes. Any additional bills that the Claimant or victim incurs subsequent to the crime, and are crime related, can be considered as well.

ALLOWABLE EXPENSES RELATED TO THE CRIME

- Medical expenses
- Mental health counseling for up to 2 years
- Funeral expenses
- Eyeglasses or corrective lenses
- Loss of earnings resulting from the crime, not to exceed $150 per week (must be employed during time of incident)
- Loss of financial support resulting from the crime, not to exceed $150 per week

EXPENSES NOT COVERED

- Property damage or loss
- Expenses related to court proceedings
- Household living expenses
- Moving expenses
- Pain and suffering, emotional distress, loss of consortium
- Appeal of a denied claim

SEXUAL ASSAULT FORENSIC EXAMINATION PROGRAM (SAFE)

The Crime Victims Compensation Board administers the SAFE program, which makes payments directly to medical professionals and facilities that conduct sexual assault examinations. Medical providers bill the SAFE program directly as state law prohibits billing patients solely for this expense.

This program does not require reporting by the victim to law enforcement.

CONTACT

502-782-8255

502-573-4817 fax

500 Mero Street, 2SC1

Frankfort, Ky 40601

crimevictims@ky.gov

kycc.ky.gov

OFFICE OF CLAIMS AND APPEALS

PPC Public Protection Cabinet

Compensation for Innocent Victims of Crime

Crime Victims Compensation

OFFICE OF CLAIMS AND APPEALS

PPC Public Protection Cabinet

This pamphlet is a summary of the statutory provisions applicable to the Crime Victims Compensation Fund and is not in itself binding to the Board. For the actual provision and rules, refer to KRS 49.

Available in Spanish.

TEAM KENTUCKY

REQUIREMENTS

The Office of Claims and Appeals – Crime Victims Compensation Board (CVCB) administers the Crime Victims Compensation Fund and considers payment or reimbursement for expenses related to crimes occurring in Kentucky when no other resources are available.

A claimant must:

- Be an innocent victim of a crime or some conduct that could be charged as a crime, or a third party who is required to pay for the victim's crime-related bills, and have no other means of payment. Conviction is not required.
- Report incident to law enforcement within 48 hours; if not reported, provide a justifiable reason.
- Cooperate with law enforcement and the prosecution except in cases of domestic violence and sexual assault.
- Provide a social security number or other U.S. government-issued ID.

REDUCTION OF BENEFITS

The CVCB is the payer of last resort. Awards are reduced by amounts already received or to be received from other sources like insurance or workers' comp claims, legal settlements, and/or restitution.

EXCEPTIONS

Injuries resulting from an automobile accident are not eligible for consideration unless it can be determined that the driver causing the accident did so intentionally or violated DUI laws.

CLAIM PROCESS

- Claim forms are downloaded from the website at kycc.ky.gov.
- Forms are reviewed to ensure all necessary information is included.
- The Claimant is notified if additional information or documentation is required.
- Staff review, gather pertinent information and verify submitted claim.
- The claim is assigned to a board member who makes a recommendation for either approval or denial of an award to the full board.
- Staff notifies claimant of recommendation. Claimant has 15 days to register disagreement.
- Commission renders a final decision
- Claimant receives a copy of the final order.

OFFICE OF CLAIMS AND APPEALS

PPC Public Protection Cabinet

The CVCB pays providers directly on behalf of the claimant for crime-related expenses, and can consider reimbursement to the claimant for crime-related out-of-pocket expenses.

The maximum award per victim cannot exceed $25,000; the maximum award for funeral/ burial expenses cannot exceed $5,000, which is included in the $25,000 cap.

PAYMENT PROCESS

The time required for processing claims depends on numerous factors, including the cooperativeness of the claimant, timely receipt of requested documentation, the complexity of issues related to the crime, as well as any issues resulting from the criminal trial.

The CVCB can consider additional bills after an initial claim has been filed, as well as emergency payments up to $500. When applicable, emergency awards are subtracted from the $25,000 cap on all awards.

Collection agencies are prohibited from activities while a claim is under consideration.

APPEAL OF A DENIED CLAIM

An appeal may be filed in Franklin Circuit Court or the circuit court in the county where the claim occurred.

In addition to the claim form, you will need to submit, if applicable,

1) Police Report
2) Itemized bills for medical or mental health counseling expenses
    a. For mental health counseling, also submit the Mental Health Counselor's Report filled out by your therapist and your treatment plan.
3) Signed funeral service contract for funeral expenses
    a. Also submit documentation showing benefit amounts received due to the death, if applicable.
4) Lost earnings
    a. Completed Employment Verification Form filled out by your employer. If you are self-employed, please submit the preceding two years' worth of tax returns.
    b. Physician's Statement if time missed from work is due to physical trauma. The Mental Health Counselor's Report will suffice for psychological trauma.
5) Loss of support
    a. Documentation outlining amount of support brought into household by the supporter at the time of the crime.
6) If you are having difficulty, please call 502-782-8255 for assistance.

Crime Victims Compensation Board – Crime Victim Compensation Form
500 Mero Street, Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

This form must be legibly written, typed, or printed, and must be signed. Incomplete submissions may not be considered. All answers may be supplemented with additional explanatory pages.

Section 1: Claimant Information

Claimant's Name: _____ SSN or Gov't ID#: _____

Relationship to Victim _____

Address: _____

Telephone #: (Primary) _____ (Other) _____ E-Mail: _____

Section 2: Victim and Offender Information

Victim's Name: _____ SSN or Gov't ID # _____

Date of Birth: ___/___/_____ Male ☐ Female ☐ Age at time of Crime ____

Address: _____

Telephone #: (Home) _____ (Other) _____

E-Mail: _____

Name of Offender(s): _____

Was the Offender charged with a crime? ☐Yes ☐No

If yes, what charge? _____

If yes, in what Court? District: _____ Circuit: _____ Juvenile: _____

Type of Crime (Check all that apply)

- ☐ Arson
- ☐ Assault
- ☐ Burglary
- ☐ Child Physical Abuse / Neglect
- ☐ Child Pornography
- ☐ Domestic Assault
- ☐ DUI / DWI
- ☐ Fraud / Financial Crimes
- ☐ Homicide (Murder)
- ☐ Human Trafficking
- ☐ Kidnapping
- ☐ Other Vehicular Crimes
- ☐ Robbery
- ☐ Sexual Assault Adult
- ☐ Sexual Assault Child
- ☐ Stalking
- ☐ Terrorism
- ☐ Other

Section 3: Financial Information

Employment at time of crime: ☐ Full ☐ Part ☐ Self ☐ Unemployed Time missed from work as a result of crime: ☐Yes ☐No

Are you applying for lost wages? ☐Yes ☐No Are you applying for loss of support? ☐Yes ☐No
These claims require completion of the Employment Verification Form. Where applicable, these claims also require completion of the Physician Statement and Mental Health Counselor's Report.

Total monthly income prior to incident: $_____
Income or payment sources at time of incident: $_____ Wages $_____ Social Security $_____ Worker's Compensation $_____ Insurance $_____ Medicare $_____ Medicaid $_____ Veteran's Benefits $_____ Other (please specify) _____

Total monthly income as a result of incident: $_____
Income or payment sources as a result of incident: $_____ Wages $_____ Social Security $_____ Worker's Compensation

$ Insurance $ Medicare $ Medicaid $ Veteran's Benefits
$ Other (please specify)

Section 4: Crime Incident Information

Date of incident __/__/__ Time of incident __:__ a.m./p.m.

Location where the incident occurred:

(Please be specific so as to provide exact location)

Date reported __/__/__ Reported To:

Law Enforcement Agency

If not reported within 48 hours of discovery, please explain:

Describe the incident:

Describe any injuries:

Section 5: Expenses

Each expense must be listed below to be considered. Each must be a direct result of the crime, and documentation must include date, type, and charge for service. If you need additional space please attach a separate page or the itemized bill(s).

5a. Medical Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5b. Mental Health Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5c. Funeral/Burial Expenses

Date of Death ☐/☐/☐ Funeral Home ☐ Address ☐

Total Funeral Expenses: $☐ Paid? ☐ Yes ☐ No If yes, by whom? ☐ Relationship to Victim: ☐

Benefits available and amounts: $☐ Life Insurance $☐ Worker's Compensation $☐ Funeral/Burial Insurance $☐ Social Security $☐ Estate $☐ Donations (including crowd-funding websites) Other: ☐

Section 6. Federal Government Information (*optional/for statistical use only)*

Ethnic Group (Victim)
- ☐ Caucasian
- ☐ African American
- ☐ American Indian or Alaskan Native
- ☐ Hispanic / Latino
- ☐ Multiracial
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ Other

Are you (please check all that apply)
☐ U.S. Citizen ☐ Handicap ☐ Kentucky Resident

Who referred you to the compensation program?
☐ Law Enforcement ☐ Hospital ☐ Victim Advocate
☐ Prosecutor ☐ Judge ☐ Other ☐

Is this a Federal Crime? ☐ Yes ☐ No

Section 7. Restitution and Civil Lawsuit

Has the victim or claimant filed or plan to file a civil suit relating to the injury received as a result of the crime? ☐ Yes ☐ No

If yes, Attorney: ☐ Telephone: ☐ E-mail: ☐

Has the Offender been ordered by a court to pay restitution to the victim or claimant? ☐ Yes ☐ No If yes, amount: $☐

Has the victim received any of the ordered restitution? ☐ Yes ☐ No If yes, amount: $☐

Section 8. Authorization and Subrogation

I hereby certify, subject to penalty, fine, or imprisonment that the information contained in this form and all attachments is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Crime Victims Compensation Board, in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund, I agree to repay such amount up to the full amount I received from the fund. I understand that compensation from any other public or private source includes but is not limited to: receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Crime Victims Compensation Board may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any sources, I agree to promptly notify the Crime Victims Compensation Board by sending copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the Crime Victims Compensation Board should the Board decide to institute an action against any person or entity for the recovery of all or any part of the compensation I received from the fund.

MEDICAL/PSYCHIATRIC/EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested by the Crime Victims Compensation Board. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

YOUR SIGNATURE: _____ DATE: _____

Attorney's Name*: _____ Address: _____

Telephone: _____ E-mail Address: _____

Attorney's Signature: _____ Date: _____

*You are <u>not</u> required to have an attorney assist in submitting your application. However, if an attorney does assist you, the attorney must sign the application as well.

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

EMPLOYMENT VERIFICATION

Complete only if applying for lost wages/ loss of support.
To be completed and signed by EMPLOYER only*. This form must be NOTARIZED*.

Employee's Name: _____ Social Security #: _____

Date of Crime: _____ Victim was employed at the time of crime ☐ Yes ☐ No

If SELF-EMPLOYED, attach copies of State and Federal taxes for the two-year period prior to the crime.

Employer's Name: _____ Telephone: _____

_____ _____ _____ _____
Address City State Zip Code

Victim missed time from work because of injuries related to the crime: ☐ Yes ☐ No

If yes, from _____ to _____

The items listed below are to be **weekly amounts:**
Gross Earnings: $_____ Net Take Home Earning Per Week: $ _____

Federal Tax Withheld: $ _____ State Tax Withheld : $_____ Social Security Withheld: $ _____

Other Deductions (itemized): $ _____ Typical days worked per week: M T W TH F Sat Sun
Attach additional pages if necessary.

Please Circle
Victim has returned to work: ☐ Yes ☐ No Victim's wage continued while off work: ☐ Yes ☐ No

If the victim's wage continued while off work, complete the following:

Deductions	Amount Per Week	Starting Date	Ending Date
Workers Comp	$		
Unemployment	$		
Insurance – Health	$		
Insurance – Other	$		
Vacation	$		
Sick	$		
Employers Group	$		
Disability	$		
Union	$		
Other	$		

_____ _____
Employer's Name and Title Employers Signature

The following must be completed by a Notary:

SUBSCRIBED AND SWORN TO BEFORE ME BY _____

THIS _____ DAY OF _____. 20____

MY COMMISSION EXPIRES: _____

Signature: _____

Seal or Stamp affixed here

Revised August 2020

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

PHYSICIAN STATEMENT

Complete only if applying for lost wages/ loss of support.
To be completed and signed by PHYSICIAN only.

Victim / Patient Name: _____

Type of Injury: _____

Date of Injury: _____ Date(s) victim/patient unable to work: _____ to _____

Victim/Patient suffered permanent disability: ☐ Yes ☐ No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines: _____

Description of injury/trauma resulting from crime and comments:

_____

_____

_____

_____

_____

_____

_____

_____

Name of Physician: _____ Specialty: _____

Office Address: _____ _____ _____ _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician's Signature Date

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

MENTAL HEALTH COUNSELOR'S REPORT

Complete only if applying for mental therapy or where applicable for lost wages.
To be completed by COUNSELOR only. *Treatment plan must be attached.*

Victim/Claimant receiving treatment: _____

Date of crime: _____ Date(s) victim/claimant unable to work: _____ to _____

The trauma and treatment is a direct result of this crime ☐ Yes ☐ No

Presenting Complaint: _____

Diagnosis of Record: _____

Description of psychological trauma resulting from crime:

Health Insurance: _____ _____
Company Name Phone Number/ Extension

_____ _____ _____ _____
Address City State Zip Code

****PLEASE ATTACH PATIENT TREATMENT PLAN****

Name of Physician/Therapist/Counselor: _____ Specialty: _____

Office Address: _____ _____ _____ _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician/Therapist/Counselor Signature Date

Revised August 2020